TRIWEST HEALTHCARE ALLIANCE

TriWest Health Care Alliance
6760 Corporate Centre
Suite 300
Colorado Springs, CO 80919
(719) 264-5000

Fax

To:	
Pikes Peak Regional Office TriCare Service Center	
Durable Medical Equipment - Health Care Finder	
Phone	(719) 264-5075
Fax Phone	(719) 590-9424

From;	
Date 04/17/97	
Phone	
Fax Phone	

REMARKS: **Durable Medical Equipment Order Form**

☐ Urgent ☐ Routine ☐ Reply ASAP ☐ Please comment

PLEASE FILL OUT INFORMATION BELOW AND FAX TO THE PIKES PEAK REGIONAL TRICARE OFFICE WITH A COPY OF THE PRESCRIPTION, 2161, PHYSICIAN REQUEST FOR AUTHORIZATION, OR HOSPITAL PHYSICIAN ORDER.

TRICARE PRIME? YES ☐ NO ☐ EXTRA? YES ☐ NO ☐ OHI?_____

PATIENT NAME: _____

Patient DOB: _____ Patient SSN:_____

SPONSOR'S NAME:_____

SPONSOR'S SSN: _____ Home Phone: _____

Address: _____ City:_____ Zip: _____

Active Duty: ☐ Rank: _____ Retired: ☐

Physician: _____

Diagnosis: Bronchospasm

Physician Order: compressor and supplies for home nebulizer

_____

Date/ Time of Discharge_____ Best Time for Delivery of DME Item _____

Item Cost: _____ Pt. Cost Share:_____ HCPC:_____

Authorization Number: _____

DME PROVIDER NOTIFIED: _____ HCF_____

CHAMPUS

Blue Cross and Blue Shield of South Carolina
CHAMPUS Fiscal Intermediary

CERTIFICATION OF NECESSITY

☒ DME ☐ OXYGEN ☐ IPPB ☐ TENS ☐ APNEA MONITOR

Information on this form must be submitted timely (i.e., preferably prior to claim submission or attached to corresponding claim). Sections A and B as well as other pertinent information must be completed in full.

Failure to complete this form, or untimely submission, will cause processing delays and/or denial of claim(s).
If referring physician is a military doctor, please include Civilian Referral Form.

A. PATIENT'S INFORMATION

NAME: _____ HEALTH INSURANCE NUMBER: _____

DIAGNOSIS, PROGNOSIS, GENERAL CONDITION: bronchospasm

Type of equipment ordered: compressor and supplies for home nebulizer

Duration of need: _____ month(s) From: _____ (Month / Year) To: _____ (Month / Year)

Date equipment prescribed: _____ Is the patient confined to a nursing facility? ☐ No ☐ Yes In a hospital? ☐ No ☐ Yes

If yes, give name of facility _____ and date of confinement _____

Other information about patient's condition: _____

B. PRESCRIBING PHYSICIAN'S INFORMATION

I, the undersigned, certify that use of the indicated equipment is medically necessary for this patient's condition and is within accepted standards of medical practice and treatment for this condition.

NAME (Type or Print): TELEPHONE: 526-7653 LICENSE NUMBER: Colo 28596

ADDRESS: Ft Carson, CO 80913 CERTIFICATION: ☒ RECERTIFICATION: ☐

SIGNATURE: DATE:

C. DURABLE MEDICAL EQUIPMENT

Is patient confined to bed? ☒ No ☐ Yes-If yes, what % of the time is patient confined to the bed (circle one)? 50% 75% 100%
Is the patient confined to the room ☒ No ☐ Yes ☐ Ambulatory inside of home ☐ Ambulatory outside of home
Is Patient disoriented? ☒ No ☐ Yes, occasionally ☐ Yes, most of the time
Is patient functionally able to walk with limited or no assistance? ☐ No, non-ambulatory ☐ Yes, with no assistance
☐ Yes, with aid of one person ☐ Yes, with aid of stationary or rolling walker ☐ Yes, with aid of cane
Is patient susceptible to decubitus ulcers and/or has decubitus ulcers? ☒ No ☐ Yes Child
Is patient able to effectively and safely utilize equipment unassisted? ☐ No ☐ Yes

D. DEXTROMETER

1. Is patient insulin dependent? ☐ No ☐ Yes
2. Patient has widely fluctuating blood sugar before meals. ☐ No ☐ Yes.
3. Patient has frequent episodes of insulin reaction. ☐ No ☐ Yes
4. Patient has shown evidence of frequent significant ketosis. ☐ No ☐ Yes
5. Other complications not mentioned above. _____

DD FORM 1 NOV 71 1289

DOD PRESCRIPTION

FOR *(Full name, address & phone number.) (If under 12 years, give age.)*

MEDICAL FACILITY	DATE

℞ *Gm. or ml.*

Compressor and supplies for home nebulizer

MFGR:	EXP DATE:
LOT NO:	FILLED BY:

℞ NUMBER | SIGNATURE, RANK AND DEGREE

EDITION OF 1 JAN 60 MAY BE USED.

REFERRAL FOR CIVILIAN MEDICAL CARE

SUBMIT CHARGES TO: ☐ REFERRING UNIFORMED SERVICES FACILITY ☐ CHAMPUS

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Home Medical Supplier	Pediatrics	

REASON FOR REQUEST (Complaints and findings)

year old with bronchospasm responsive to bronchodilators. Needs compressor and supplies to give nebulizer treatments at home.

ANTICIPATED LENGTH OF TREATMENT

PROVISIONAL DIAGNOSIS

bronchospasm

DOCTOR'S SIGNATURE	APPROVED *	PLACE OF CONSULTATION	☐ ROUTINE ☐ TODAY
		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade, rank; rate; hospital or medical facility)

DD FORM 1 OCT 78 2161

PATIENT RESPONSIBLE FAMILY MEMBER SIGNATURE _____

SPONSOR'S FULL SSAN _____

IMPORTANT INFORMATION (on reverse side)

Below is a list of local home oxygen companies that are J.A.C.H.O. certified. They all provide home care services and equipment.

P S A HealthCare
628 Elkton St.
Colorado Springs, CO. 80907
(719) 536-9790
(800) 289-5551

NMC Homecare
1506 N. Hancock Ave.
Colorado Springs, CO 80903
(719) 633-8803
(800) 289-1937

Abbey Home Healthcare
3344 Adobe Ct.
Colorado Springs, CO. 80907
(719) 577-4503
(800) 253-2574

MRE
3636 Jeannine Dr.
Colorado Springs, CO. 80917
(719) 597-9730
(800) 397-5438

Homedco
5050-C List Dr.
Colorado Springs, CO. 80919
(719) 594-9090

LinCare
4239 N. Nevada Ave.
Colorado Springs, CO. 80907
(719) 548-0202
(800) 695-6022

IGP Medical
306 S. Chestnut
Colorado Springs, CO. 80909
(719) 473-1880